Associates In Family Eyecare
2249 W Eisenhower Blvd
Loveland CO 80537
970.669.4587
www.banfordstraub.com

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. ***Please read this document carefully.***

Your rights:

Ask to limit what we use or share

- No use or disclosure of your health information not described in the NPP will be made without your consent.
- You can revoke any previously-given consent at any time.
- You can request we ***not*** share certain health information for treatment, payment, or our operations.*
- If you pay for a service or health care item out-of-pocket in full, you can ask us to not share that information for the purpose of payment or our operations with your health insurer.*

Get an electronic or paper copy of your medical record

- You can ask to see or receive an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record You can ask us to correct health information about you that you think is incomplete or incorrect. Ask us how to do this.*

Request confidential communications You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.*

Get a copy of this privacy notice You can ask for a paper copy of this notice at any time.

Choose someone to act for you

- If you have given someone medical power or attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

Request a list of those with whom we've shared information You can receive an accounting of the times we've shared your information for six years prior to the request date, who we shared it with, and why. We will include all the disclosures except those about treatment, payment, and health care operations, and certain other disclosures (such as any you requested we make). We'll provide one accounting per year for free, but will charge a reasonable, cost-based fee if you request another within 12 months.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

**NOTE*: We reserve the right to deny any requests if request would result in a reduction of level of care, if a law requires us to behave otherwise, or for any other reason. We will say "yes" to any reasonable request.

In the following cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care.
- Share information in a disaster relief situation.

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In the following cases we never share your information without your permission in writing:

- Marketing purposes
- Sale of your information
- Psycotherapy notes

Typical use and sharing of your health information:

Treatment We can use your health information and share it with other professionals who are treating you. We can also share your health information with other doctors in our office to consult on your case. *Example*: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization We can use and share your health information to run our practice, improve your care, and contact you when necessary. *Example*: We use health information about you to manage your treatment and services.

Bill services provided We can use and share your health information to bill and receive payment from health plans or other entities. *Example*: We give information about you to your health insurance plan so it will pay for your services.

Other circumstances to use or share your health information:

We may share your information about you to aid with public health and safety issues, do research, comply with the law, work with a medical examiner or a funeral director, respond to organ and tissue donation requests, address workers' compensation, law enforcement, and other government requests, or to respond to lawsuits and legal actions.

Should the practice be sold, we reserve the right to transfer access to your information to the new owner.

Our responsibilities:

We are required by law to maintain the privacy and security of your protected health information. We will inform you promptly if a breach occurs that may have compromised the privacy or security of your information. We must follow the duties and privacy practices described in this notice and give you a copy of it.

For more information, visit:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticenpp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website.

Contact Us

Our contact person for all questions, requests, or for further information related to the privacy of your health information is:

Teri Dutton, Office Manager
officemanager@banfordstraub.com
(970)669-4587

Acknowledgement of Receipt

A confirmation of receipt of this notice is found on your patient paperwork. Please sign that document. Refusal to sign will result in refusal of services.

I acknowledge that I have received a copy of the privacy policy for Associates in Family Eyecare.

Name _____ Signature _____ Date _____
(please print) *(MM/DD/YYYY)*